DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 95-26

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (A)(30) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 1994-1995 $ 112.5m
b. FFY 1995-1996 $ 136.65m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4,19-A Part I Pages 112(d),112(f)(1), 113,113(a),113(b),113(c),117(a),117(b),118,118(a), 120,120(a),137,138,144,145,146,148,148(b),149(a), 149(b),153(b),181,185,212,226,226(a),231,231(a), 232,232(a), *** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 112(d),112(f)(113,113(a),117(a),118,120,137,138,144,145,146 148,148(b),149(a),149(b),153(b),181,185,212, 226,226(a),231,231(a),232,232(a)

No Previous Pages: 113(b),113(c),117(b),118(a 120(a)

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
June 30, 1995

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

[redacted]

21. TYPED NAME:
Sue Kelly

22. TITLE: [redacted] Regional Administrator
Division of Medicaid and Health Operations

23. REMARKS:
[redacted] submission, Attachment 4.19-A Part I pages [redacted] have been revised and renumbered 112(d), 112(f), 113, [redacted] 138, 118(a), 120, 144, 149(a) and 226. In addition the [redacted] were submitted and approved. 148(a), and 181(b). The [redacted] were originally submitted with the SPA and approved: 113(a), [redacted] 120(a), 137, 138, 145, 146, 149(b), 153(b), 185, 212, 226(a), 231, 231(a), 232 and 232(a). Pages 148, 148(a) and 181(b) added per Letter from State dated 01/22/01

FORM HCFA-179 (07-92) *Instructions on Back*

(ii) $50 million shall be allocated as follows:

(a) An amount not to exceed $21 million shall be allocated among hospitals which qualify for distributions as financially distressed hospitals in accordance with section 86-1.66 of this Subpart and which are not eligible for payments pursuant to subparagraph (i) of this subdivision according to the following formula: each hospital shall receive the result of $45 million multiplied by the ratio of such hospital's aggregate revenue derived from the provision of inpatient hospital services to patients eligible for payments made by state governmental agencies, based upon the 1993 institutional cost report data, to the sum of such revenue for all hospitals which qualify for distributions as financially distressed hospitals in accordance with section 86-1.66 of this Subpart.

(b) An amount not to exceed $29 million shall be allocated among hospitals which qualify for the supplementary low income patient adjustment in accordance with section 86-1.84 of the Subpart and which are not included in subparagraph (i) of this subdivision according to the following formula: each hospital shall receive the result of $30 million multiplied by the ratio of such hospital's aggregate revenue from the provision of inpatient hospital services to patients eligible for payments made by state governmental agencies, based upon 1993 institutional cost report data, to the sum of such revenue of all voluntary non-profit and private proprietary hospitals which qualify for the supplementary low income patient adjustment in accordance with section 86-1.84 of this Subpart; and

(c) Any remaining funds shall be allocated among all hospitals designated in subparagraph (i) of this subdivision which qualify for distributions as financially distressed hospitals in accordance with section 86-1.66 of this Subpart according to the following formula: each hospital shall receive the result of the balance of funds available multiplied by its proportionate share of the aggregate revenue from inpatient hospital services to patients eligible for payments by state governmental agencies, based upon the 1993 institutional cost report data, of all such hospitals.

(iii) The Commissioner may increase the rate of payments through March 31, 1996 by an amount not to exceed $6.25 million to hospitals designated in subparagraph (i) of this subdivision. In allocating such rate adjustments, the commissioner may consider such factors, including, but not limited to the relative hardship experienced by a hospital, and the estimated effect of any reductions in rates of payment of such hospitals for patients eligible for payments by state governmental agencies through June 30, 1996 as contained in the cost containment provisions for the medical assistance

(d) Secondary Payor payments. (1) Co-insurance and deductibles. (i) Effective for all patients discharged after January 1, 1988 but before August 1, 1988 and notwithstanding the provisions of paragraph (2) of this subdivision, the sum of the payments made to a provider by primary payor and a secondary payor(s) assuming liability for coinsurance and deductibles for an acute care stay shall equal the case based payment per discharge amount determined on behalf of the primary payor pursuant to the provisions of section 86-1.51. For purposes of determining the secondary payor's or payors' or patient's coinsurance payment(s), the coinsurance percentage(s) shall be

including, but not limited to, peer group cost ceilings or guidelines.

(2) Non-Medicare discharges. Non-Medicare discharges for each hospital shall be all 1987 discharges not related to beneficiaries of Tittle XVIII of the federal Social Security Act excluding exempt

paragraph (1) of this subdivision, based upon that hospital's pro rata share of the sum of such costs for all eligible hospitals.

(3) The following costs shall then be subtracted from the hospital-specific operating costs determined pursuant to paragraph (2) of this subdivision:

(i) transfer costs as defined in subdivision (f) of this section, including a proportional amount of hospital

and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

(g) Effective April 1, 1995, the capital related inpatient expense component of the rate shall be based on the budgeted capital related inpatient expense applicable to the rate year decreased to reflect the percentage amount by which the budget for the applicable base year's capital related expense exceeded actual expense.

(h) Effective April 1, 1995 rates of payment for inpatient acute care services associated with the capital related inpatient expense component and the capital cost per visit components shall be adjusted to exclude such expenses related to the following:

(i) 44% of major moveable equipment
(ii) staff housing.

(b) An estimated real non-Medicare statewide increase in case mix index shall be determined by dividing the estimated real rate year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 by the estimated real statewide base year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 and subtracting one from the result.

(c) The estimated statewide non-Medicare case mix change to be attributable to changes in coding practices shall be determined by subtracting the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph from the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this subparagraph.

(d) A statewide maximum difference shall be determined by subtracting the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph from the maximum allowable increase in the non-Medicare statewide average reported case mix as identified in paragraph (1) of subdivision (b) of this section.

(e) If the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this paragraph is less than or equal to the maximum allowable increase in the non-Medicare statewide case mix index as identified in subparagraph (1) of subdivision (b) of this section, the case mix adjustment percentage shall be zero percent.

(f) If the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this subparagraph is greater than the maximum allowable increase in the non-Medicare statewide case mix index as identified in paragraph (1) of this subdivision and the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph is less than the maximum allowable increase in the non-Medicare statewide case mix index, the case mix adjustment percentage shall be determined as follows:

(l) Adjustments to rates made pursuant to this section shall be made prospectively, based on the methodology for the calculation of rates of payment for such prospective rate period, provided however, that no recalculation of bad debt and charity care allowance percentages determined in accordance with section 86-1.65 shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment. Adjustments to rates to reflect 1987 data and statistics may be made retrospectively and such retrospective adjustments shall, to the extent practicable, be cumulated for one comprehensive adjustment. This comprehensive adjustment must be appealed within 120 days of receipt by the facility of the notice of such revised rates.

(m) Hospitals may appeal the determination of allowable cumulative increases in case mix for the rate year pursuant to section 86-1.60 of this Subpart based on such factors as changes in hospital services delivery and referral patterns. An appeal pursuant to this section must be submitted within 90 days of receipt of notice of such determination and any modified rate certified pursuant to this subdivision shall be effective as of the date of the case mix adjustment.

(n) The appeal process shall be in accordance with section 86-1.17(c), (e) and (f) of this Subpart, provided, however, that documentation sufficient to support such appeal, including verifiable costs and statistics, must accompany every appeal. Letters of intent to appeal or appeal packages lacking such documentation shall not be accepted or considered to be an appeal.

(o) Hospitals may not request and the Commissioner shall not consider any pending or further appeals for an adjustment to rates of payment based on costs associated with technology advances or changes in medical practice or universal precautions.

for the purposes of regional disproportionate share pool distributions in accordance with subdivision (k) of this section.

(4) Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in subparagraph (iii) of subdivision (d)(2) of this section.

(5) Targeted need share shall be defined as the ratio of each hospital's nominal payment amount to the nominal payment amounts for all hospitals [in the region] statewide other than major public general hospitals.

(1) For rate years commencing January 1, 1991 and thereafter, each eligible major public general hospital shall receive a portion of its bad dept and charity care need equal to 110 percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.

(2) The balance of the statewide resources after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision shall be aggregated on a statewide basis and treated as a common pool for statewide distributions and distributed to voluntary [~~sector~~], non-profit, private proprietary, and public general hospitals, other than major public general hospitals, on the basis of each hospital's targeted need share.

(i) Need calculations shall be based on need data for the year 2 years prior to the rate year.

(ii) For the rate periods commencing January 1, 1991 and thereafter, the scale specified in subparagraph (iii) of this paragraph shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year 2 years prior to the rate year and their patient service revenues for the year 2 years prior to the rate year.

(iii) The scale utilized for development of each hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to that Portion of Targeted Need
0 - 1%	35%
1+ - 2%	50%
2+ - 3%	65%
3+ - 4%	85%
4+ - 5%	90%
5+	95%

TN 95-26
Supersedes TN 91-22A
JUN 06 2001
APR 01 1995

year bad debt and charity care imputed nominal payment amount for such major pubic hospital determined in accordance with section 86-1.65(b) of this Subpart for voluntary sector hospitals. The coverage ratio shall be computed as the ratio between the sum of the dollar value of the amount committed for payments in accordance with section 86-1.65(d)(1) and (2) of this Subpart for the rate period that would be allocated to voluntary sector hospitals and the base year nominal payment amount for such hospitals. For the rate periods commencing on or after January 1, 1994, provided the election pursuant to paragraph (a) of this section continued for such periods and a major public general hospital received an adjustment in accordance with this paragraph for 1993, the supplementary bad debt and charity care adjustment shall be the higher of such adjustment for the 1991 rate period or 1993 rate period. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital. For rate periods commencing prior to January 1, 1991, this additional amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable cost and divided by Medicaid service units to arrive at a cost per unit of service For rate periods commencing January 1, 1991, and thereafter, this additional amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable costs and divided by Medicaid service units of those patients eligible for Federal financial participation under Title XIX of the Federal Social Security Act in medical assistance pursuant to Title 11 of Article 5 of the Social Services Law to arrive at a cost per unit of service.

(c) The supplementary bad debt and charity care adjustment provided in accordance with this section shall be adjusted to reflect actual distributions pursuant to section 86-1.65 (d) of this Subpart.